TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Property & Casualty Insurance Company of Hartford

MFDR Tracking Number
M4-17-2193-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bill has been denied stating medication not authorized as doctor was not authorized. Reconsiderations was submitted and still denied. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $335.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Medications were denied by Peer Review."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2016	Pharmacy Services – Hydrocodone	$116.19	$77.36
May 25, 2016	Pharmacy Services – Tramadol	$132.46	$97.70
May 25, 2016	Pharmacy Services – Methocarbamol	$86.45	$40.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 71 – Prescriber is not covered.

Issues

1. Did Property & Casualty Insurance Company of Hartford (Hartford) raise an issue of medical necessity in accordance with 28 Texas Administrative Code §133.307?
2. Is Hartford's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed service?

Findings

1. Memorial is seeking reimbursement of $335.10 for a Hydrocodone/Acetaminophen 10/325 tablets, Tramadol HCl 50 mg tablets, and Methocarbamol 500 mg tablets dispensed on May 25, 2016. In its position statement, Hartford stated, "Medications were denied by Peer Review." 28 Texas Administrative Code §133.307(d)(2)(F) states:

   > The [carrier's] response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

   Review of the submitted documentation finds no evidence that an issue of retrospective review for medical necessity was presented to Memorial prior to the date the request for medical fee dispute resolution was filed with the division. The division concludes that the defense presented in Hartford's position statement shall not be considered for review because those assertions constitute new defenses pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Per the remittance advice dated January 13, 2017, Hartford denied the disputed drugs with claim adjustment code 71 – "PRESCRIBER IS NOT COVERED." Review of available information failed to support Hartford's denial. The services will be reviewed in accordance with applicable fee guidelines.

3. 28 Texas Administrative Code §134.503 applies to the drugs in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount … or
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider; or
   (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

Drug Name	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Hydrocodone/ Acetaminophen 10/325 tablets	00603388728 Generic	$0.97812	60 tablets	($0.97812 x 60 x 1.25) + $4.00 = $77.36	$116.19	$77.36
Tramadol HCl 50 mg tablets	65162062711 Generic	$0.83290	90 tablets	($0.8329 x 90 x 1.25) + $4.00 = $97.70	$132.46	$97.70
Methocarbamol 500 mg tablets	31722053305 Generic	$0.48250	60 tablets	($0.4825 x 60 x 1.25) + $4.00 = $40.19	$86.45	$40.19
					Total	$215.25

The total allowable reimbursement is $215.25. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $215.25.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $215.25, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.